South Carolina Department of Disabilities and Special Needs
PDD Waiver Acknowledgement of Rights and Responsibilities

Name: _____

I acknowledge that this information is to assist me in understanding the Pervasive Developmental Disorder (PDD) Waiver services, my rights, my responsibilities, and my benefits. I will keep this information in a place where I can find it. I can contact my Service Coordinator/Early Interventionist at _____ if I have any questions or need assistance.

I. By receiving services through the Pervasive Developmental Disorder (PDD) Waiver

1. I have the right to be treated with dignity and respect by my Service Coordinator/Early Interventionist and all providers of my PDD Waiver services.

2. I have the right to confidentiality.

3. I have the right to receive a full explanation of all the forms that I am asked to sign.

4. I have the right to be told about all services available from SCDDSN.

5. I have the right to know the name of my Service Coordinator/Early Interventionist and how I can contact him or her during working hours.

6. I have the right to participate in the development of my single plan/IFSP/FSP, have my single plan/IFSP/FSP explained to me and have a copy provided.

7. I have the right to choose the agency or provider for each of my PDD Waiver services from all qualified/enrolled providers (a list for each PDD Waiver service is available online at www.state.sc.us/ddsn/). My decision to receive services from a provider cannot be based on race, color, sex, religion or national origin.

8. I have the right to contact providers to evaluate service quality and gather information to assist in making an informed choice.

9. I have the right to change my provider by notifying my Service Coordinator/Early Interventionist.

10. I have the right to file an appeal if I disagree with any decision or action concerning my services or participation in the PDD Waiver.

11. I have the right to complain about waiver services/providers by contacting my Service Coordinator/Early Interventionist.

12. I have the right to discontinue participation in the PDD Waiver by contacting my Service Coordinator/Early Interventionist.

13. I have the right to be informed about any potential risk associated with waiver services. I have the right to assume that risk and be responsible for any consequences.

14. I have the right to refuse to participate in a PDD Waiver service, but understand that I must receive a PDD Waiver service at least every thirty (30) days. If I do not receive a PDD Waiver service at least every thirty (30) days, I will be terminated from the PDD Waiver with written notification and appeals information.

II. As a PDD Waiver participant:

1. I will treat my Service Coordinator/Early Interventionist and service providers in a considerate, respectful and courteous manner.

2. I will inform my Service Coordinator/Early Interventionist and all service providers in advance when I will be away from my home on dates of scheduled services/visits.

3. I will be present at the time of the provider's scheduled visits. This means I will be present at all team meetings and workshop sessions and must be trained in all therapeutic procedures and be an active contributor to my child's program to carry over and reinforce targeted behaviors and skill learning. I agree to meet with the Line Therapy supervisor weekly.

4. I will admit the service provider into my home.

5. I will not ask the service provider to perform tasks that are against the law or that are not a part of my single plan/IFSP/FSP.

6. I understand the PDD waiver will not provide for all of my service needs.

7. I will follow the agreed upon single plan/IFSP/FSP.

8. I will provide accurate and complete information about:

    - past and present medical histories;
    - my family or others who can provide supports;
    - other services being provided to me;
    - changes in my condition or situation, i.e. hospitalization, additional caregiver(s), income, and other events impacting my care;
    - changes in my address, phone number(s) and persons assisting me with my care; and
    - timekeeping records that I may be required to sign in regards Early Intensive Behavioral Therapy services.

9. I understand that the PDD Waiver and DDSN do not provide emergency care. In case of medical emergency, I must contact my physician, go to the hospital or call 911.

10. I understand that I must be available for and participate in my annual plan meeting and that not participating may lead to the suspension of my waiver services.

I understand that not abiding by the rights and responsibilities indicated in this document may lead to the termination of wavier services.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Service Coordinator/Early Interventionist Date